MACPAC

Medicaid and CHIP Payment and Access Commission

Statement of

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Medicaid and CHIP Payment and Access Commission

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Medicaid and CHIP Payment and Access Commission
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Summary

The Medicaid and CHIP Payment and Access Commission (MACPAC) has identified five priorities for 2014: implementation of the Patient Protection and Affordable Care Act (ACA), children's coverage, cost containment, issues for high-cost high-need enrollees, and Medicaid administrative capacity. For testimony today, we focus our remarks on Medicaid provisions set to expire in 2014.

Transitional Medical Assistance (TMA). TMA provides additional months of Medicaid to low-income parents and children who would otherwise lose coverage due to income increases from additional hours of work. Originally TMA was limited to four months but has been set at six to twelve months since 1990.

- Reducing moves in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, and reduces the likelihood of inpatient hospital admissions and emergency room visits. Churning between insurance programs is also disruptive for the plans, providers, and government entities that must process those changes. Although some churning is inevitable, steps can be taken to reduce churning that is disruptive to care delivery. For states, eliminating the sunset date would end the uncertainty around TMA's future and the possibility they might have to revert to TMA rules from 1990.

- MACPAC recommends eliminating the sunset date for Section 1925 TMA. The Commission also recommends that states expanding Medicaid to the new adult group be allowed to opt out of TMA, since these states have no eligibility gap between Medicaid and subsidized exchange coverage.

Express Lane Eligibility (ELE). ELE is an optional program to streamline enrollment of low-income children into coverage. A key strategy to promote children's enrollment under CHIP, it is now a part of outreach and enrollment efforts in Medicaid. According to HHS, 13 states have implemented ELE, garnering $3.6 million in net annual administrative savings. MACPAC will monitor the use and effectiveness of ELE and report to the Congress on improvements.

CHIPRA Bonus Payments. States can earn bonuses if they implement at least five of eight outreach and retention efforts and substantially increase enrollment of children eligible for, but not enrolled in, Medicaid. Starting in 2014, four of these strategies are now required. The Commission will examine the role of bonus payments as part of its work on the future of CHIP.

Child Health Quality Measures. CHIPRA included several provisions to improve quality of care for children, including requirements that the Department of Health and Human Services (HHS) identify and maintain a core set of child health quality measures for voluntary use in Medicaid and CHIP, and award grants to states for demonstration projects. MACPAC strongly supports efforts to measure and improve health care quality for all Medicaid and CHIP enrollees although it has not made a formal recommendation on future funding.

Qualifying Individual (QI) Program and Special Needs Plans (SNPs). MACPAC has been exploring how to improve care coordination for individuals with both Medicare and Medicaid coverage. The QI program requires states to pay the Part B premium for certain low-income Medicare beneficiaries with 100 percent federal funding. This is an important source of financial protection for approximately 500,000 QIs. An extension would enable many low-income Medicare beneficiaries to continue to receive help paying their Medicare premiums and remove uncertainty for states as well. MACPAC has not made recommendations specifically regarding the extension of statutory authority for Medicare special needs plans.

Statement of Diane Rowland, ScD, Chair

Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Ranking Member Pallone and Members of the Subcommittee on Health. I am Diane Rowland, Chair of the Medicaid and CHIP Payment and Access Commission (MACPAC) and I am pleased to be here today to share MACPAC's expertise and insights as this Committee considers the extension of several legislative provisions affecting Medicaid and the State Children's Health Insurance Program (CHIP).

MACPAC's Charge and 2014 Priorities

MACPAC was created in 2009 and began its work in 2010 to provide the Congress with analytic support on a wide range of Medicaid and CHIP policy issues including:

- eligibility and enrollment,
- access to care,
- payment policies,
- benefits and coverage policies,
- quality of care, and
- interaction of Medicaid and CHIP with Medicare and the health care system generally.

MACPAC is statutorily required to submit two reports to the Congress annually that review Medicaid and CHIP policies and make recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services (HHS), and the states on a wide range of issues affecting these programs. The 17 commissioners, appointed by the U.S. Government Accountability Office (GAO) have diverse backgrounds in medicine, nursing, public health, and managed care, and include

parents and caregivers of Medicaid enrollees and experts in the administration of Medicaid and CHIP at the state and federal levels. They represent different regions across the United States and bring varying perspectives and experience to the Commission's deliberations.

As the Commission prepares its analytic agenda for 2014, it has identified the following five priority areas as the focus of its analyses:

- implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), focusing on areas of interaction among Medicaid, CHIP and exchange coverage,
- children's coverage and the current status and future of CHIP,
- cost containment and delivery and payment system improvements to promote efficiency and value,
- Medicaid's role in providing care for high-cost high-need enrollees including those dually eligible for Medicare and Medicaid, and
- state and federal administrative capacity to manage the programs.

For our testimony today, however, I will focus my remarks as requested on Medicaid legislative provisions set to expire during 2014. The Commission does not have formal recommendations on all of these provisions, but will offer insights from our ingoing work as appropriate. In crafting our analyses and recommendations to the Congress, the Commission seeks to improve program efficiency and reduce complexity in Medicaid and CHIP. Our comments on the provisions below reflect these goals.

Expiring Provisions and Related MACPAC Recommendations

Transitional Medical Assistance

Transitional Medical Assistance (TMA) provides additional months of Medicaid coverage on a temporary basis to low-income parents and their children who would otherwise lose coverage due to increases in earnings. The authorization and funding for TMA, under Section 1925 of federal Medicaid law, is currently set to expire after March 31, 2014. TMA has been available since 1974. This extension of temporary Medicaid coverage was intended to ensure that parents would not forgo work opportunities out of fear of losing Medicaid coverage (U.S. House of Representatives 1972, GAO 2002).

As originally enacted, TMA provided four months of extended Medicaid coverage, with no sunset date. However, since 1990, the Congress has extended TMA to provide at least 6 and up to 12 months of coverage for working families under the authority of Section 1925 of federal Medicaid law. Such extensions lengthened the bridge from Medicaid to the workforce for many families, encouraging additional work earnings. Most recently, the Bipartisan Budget Act of 2013 (H.J. Res. 59) extended TMA funding and authorization by three months, from December 31, 2013 to March 31, 2014.

National data on TMA enrollment and expenditures are not available. A 2011 survey of states by GAO found that, in the 43 responding states, over 3.7 million individuals were enrolled in TMA (Table 1). The 36 states that provided GAO with expenditure data reported a total of $4.1 billion in TMA spending in 2011—less than 1.4 percent of these states' total Medicaid benefit spending (GAO 2013). There is also little information on the number of states implementing various options permitted under TMA.[1]

TMA is only available to the very lowest income parents and children who are enrolled in Medicaid under Section 1931 of the Social Security Act. Section 1931 was created in the welfare reform legislation of 1996. Prior to welfare reform, individuals eligible for the cash welfare program, Aid to Families with Dependent Children (AFDC), were automatically eligible for Medicaid—and only these individuals could qualify for TMA. When AFDC was eliminated by welfare reform, that eligibility pathway to Medicaid for low-income families was replaced by Section 1931 so that parents and children who would have been eligible for the state's AFDC program could still qualify for Medicaid. By linking this new pathway to TMA, the Congress maintained a way for the poorest families to convert from welfare assistance to work without losing health insurance coverage during the transition. Current Section 1931 eligibility levels vary by state from 13 percent of the federal poverty level (FPL) in Alabama (approximately $2,500 in annual income for a family of three) to levels above 100 percent in a number of states (CMS 2013a).

Adults who will be newly eligible for Medicaid under the ACA expansion of up to 133 percent FPL do not qualify for TMA, as newly eligible adults are not eligible under Section 1931. Similarly, TMA is not available to children or other enrollees eligible through other Medicaid pathways (CMS 2013a).

Without further Congressional action, TMA will revert to its original four-month duration on April 1, 2014. In reverting to TMA's pre-1990 eligibility policies, states would need to make significant changes to their eligibility systems that would increase costs, both for states and the federal government. States would also lose some of the flexibility they currently have under Section 1925 TMA. For example, states may currently require TMA beneficiaries to enroll in employer-sponsored insurance if offered to them. States using this option must pay the enrollees' share of premiums and cost sharing. At least 23 states use this premium assistance option under TMA to purchase employer-sponsored insurance—an option that would disappear if Section 1925 TMA is not

renewed (GAO 2012). This option currently provides the opportunity for low-income individuals to transition to employer-sponsored insurance rather than abruptly facing the premiums and cost-sharing requirements that might discourage them from working or working more hours.

The Commission recognizes the importance of providing incentives to promote increased earnings and employment opportunities for the lowest income Americans and that TMA has helped many to move on to employment without compromising ongoing health care during the transition. We also recognize that expanded coverage through Medicaid under the ACA raises issues regarding the future of TMA in expansion states. However, in non-expansion states, there is a gap in coverage between states' Section 1931 income levels and eligibility for subsidized exchange coverage, which makes the role of TMA important for those with income below 100 percent FPL for whom subsidized coverage is not available. In expansion states, by contrast, those individuals who lose TMA after four months could be eligible for Medicaid's new adult group.

For enrollees, changes in income and family situations can cause a change in health coverage in terms of covered benefits, cost sharing, providers, and health plans. Reducing moves in and out of Medicaid, such as through TMA, has been shown to lower average monthly per capita spending in Medicaid, increase utilization of preventive care, and reduce the likelihood of inpatient hospital admissions and emergency room visits (Ku et al. 2009). Churning between insurance programs is also disruptive for the plans, providers, and government entities that must process those changes.

For states, eliminating the sunset date for TMA would end the uncertainty around TMA's future and the possibility they might have to revert to TMA rules from 1990. It also reduces the administrative burden of more frequent eligibility determinations that would be associated with four-month TMA.

For providers and health plans, the continuation of 6- to 12-month TMA would reduce the administrative burden associated with individuals moving on and off of Medicaid. Longer tenure by

enrollees with the same plan or provider can help ensure that efforts to improve care management and quality improvement are not compromised because of churning.

Some churning is inevitable, but the Commission's recommendation to eliminate the sunset date for TMA seeks to reduce churning that is disruptive to care delivery. The eligibility of parents and childless adults enrolled in Medicaid must be redetermined annually, with changes in income or family status potentially leading to a change in source of coverage. Steps can be taken, however, to smooth transitions and mitigate the consequences of churning—thus ensuring continued coverage and preserving access to care.

MACPAC recommendation. MACPAC recommended in its March 2013 report that the Congress end the sunset date for Section 1925 TMA. Ending the sunset date for TMA would ensure that low-income parents would continue to receive 6 to 12 months of Medicaid coverage after increasing their earnings. Such transitional Medicaid coverage removes one disincentive for parents to return to work or work more hours. Ensuring stable coverage also helps ensure that Medicaid enrollees continue to receive needed to care for ongoing conditions, and helps prevent uninsurance. Ending the sunset date for Section 1925 TMA would also end the perennial uncertainty states face as to whether they will need to reinstitute TMA policies from 1990 and lose the flexibility to implement policies such as premium assistance for employer-sponsored insurance.

According to Congressional Budget Office (CBO) estimates provided to MACPAC in December 2013, ending the sunset date for TMA would actually save the federal government $1 billion to $5 billion over the five-year period from 2015 to 2019. The savings result in part from 6- to 12-month TMA replacing forms of coverage more costly to the federal government, such as Medicaid coverage of newly eligible individuals at 100 percent federal matching rate for 2014–2016 in expansion states.

The Commission also recommended in March 2013 permitting expansion states to opt out of TMA altogether, since these states have no eligibility gap between Medicaid and subsidized exchange coverage. Combined, the two parts of the Commission's March 2013 TMA recommendation were originally projected by CBO to have little effect on federal spending. However, the same policy is now projected by CBO to increase federal spending by $5 billion to $10 billion in the five-year period between 2015 and 2019, because of changes in how CBO projects the federal cost of expansion states opting out of TMA. The Commission will restate its support for these strategies for promoting insurance stability in its upcoming March 2014 report to the Congress.

Other Expiring Provisions

Express Lane Eligibility

Express Lane Eligibility (ELE) is an optional state program designed to help streamline the enrollment of low-income children into Medicaid and CHIP. Under this option, states may rely on the income and eligibility information of other federal programs, including the National School Lunch Program and the Supplemental Nutrition Assistance Program, to determine whether a child is eligible for Medicaid or CHIP. This has been a key strategy to promote children's enrollment under CHIP and is now a part of outreach and enrollment efforts for Medicaid under the ACA. It is one of eight outreach, enrollment, and retention strategies states could implement to increase enrollment of eligible children in both Medicaid and CHIP and qualify for performance bonus payments between fiscal year (FY) 2009 and FY 2013. ELE has been implemented by 13 states and the U.S. Department of Health and Human Services (HHS) estimates that there are 180,000 annual new enrollments and 825,000 annual renewals attributable to ELE, with $3.6 million in net annual administrative savings (Hoag 2013). ELE was most recently extended through September 30, 2014.

Current ELE authority applies only to children. States may receive permission from the Centers for Medicare & Medicaid Services (CMS) to use ELE for adults in Medicaid or CHIP through a Section 1115 waiver. As of 2013, 2 of the 13 states—Alabama and Massachusetts—that have implemented ELE have used waivers to extend ELE provisions to adults.

In its May 2013 public meeting, the Commission reviewed the results of an HHS interim evaluation report on the ELE option. The final evaluation report was submitted to the Secretary of Health and Human Services in December 2013. The Commission will review and assess the information provided in the Secretary's report in public session and, consistent with its statutory charge, will provide the Congress with our comments on the report within six months of the report's release and make recommendations to the Congress as appropriate.

MACPAC will continue to monitor the use and effectiveness of ELE for the current program as well as under the simplified and streamlined Medicaid and CHIP enrollment processes under the ACA. We will report to the Congress on the use of the ELE option beyond fiscal year 2014 and offer areas for improvement of income verification processes as well as issues related to data quality and availability.

CHIPRA Bonus Payments

To promote broader enrollment of children eligible for Medicaid or CHIP coverage, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) created a fund for performance bonuses to states that experienced substantial increases in enrollment of children in Medicaid (not CHIP) and implemented at least five of eight specified outreach and retention efforts in their Medicaid and CHIP programs. Rather than promoting an expansion of eligibility, these bonus payments were structured to incentivize activities that would reduce uninsurance and increase enrollment among the poorest uninsured children who were already eligible for Medicaid. In the

context of the Commission's deliberations on the future of CHIP, we plan to explore how bonus payments might be used to incentivize other activities to reduce uninsurance among low-income children.

CHIPRA bonus payments were authorized for FY 2009 through FY 2013. From FY 2009 to FY 2013, $1.1 billion has been paid to 27 states that have met the specified requirements and increased child Medicaid enrollment (CMS 2013b). Most recently, $307 million in bonus payments were made to 23 states on December 30, 2013 (Table 2).

While the ACA extended funding for the CHIP program by two years (from FY 2013 to FY 2015), CHIPRA bonus payments were not extended. In fact, the ACA explicitly called for the termination of CHIPRA bonus payments after FY 2013 (§2101(c) of the ACA). The context for CHIPRA bonus payments arguably has changed because of the ACA. Four of the eight criteria for states to qualify for bonus payments are now required for children's eligibility in Medicaid and CHIP, beginning in 2014, so all states must comply. These are: no asset test; no requirement for an in-person interview; use of the same application and renewal forms in both Medicaid and CHIP; and administrative renewal based on information available to the state.[2] (A list of qualifying outreach and enrollment strategies by states receiving bonus payments can be found in Table 3.) With the implementation of the ACA and intensive focus on outreach to those who are eligible but not enrolled in coverage, children's enrollment in Medicaid can be expected to increase in 2014 more due to the ACA than due to the bonus payment incentives.

The context for CHIP serving lower-income children with incomes too high to qualify for Medicaid has changed since the program's enactment in 1997. Effective in 2014, the ACA offers coverage opportunities under Medicaid and exchange plans for many low-income families. The Commission is examining the future of CHIP in this context and plans to provide information and analyses to

Congress in both its March and June 2014 reports. The Commission will examine the potential role of bonus payments as part of this work on the future of CHIP.

Child Health Quality Measures

CHIPRA included a number of provisions aimed at improving quality of care for children. These included requirements for the Secretary of Health and Human Services to identify, publish, and update a core set of child health quality measures for voluntary use in Medicaid and CHIP, provide technical assistance and a standardized reporting format for states, and award grants for demonstration projects aimed at improving the quality of children's health care under Medicaid and CHIP. An appropriation of $45 million for each of FY 2009 through FY 2013 ($225 million total) was made available for these activities until expended. A similar set of provisions aimed at adults was included in the ACA with an appropriation of $60 million for each of FY 2010 through FY 2014.

MACPAC strongly supports efforts to measure and improve the quality of health care for all Medicaid and CHIP enrollees, although the Commission has not voted on a formal recommendation regarding the extension of funding. In a June 2011 comment letter to the Secretary of Health and Human Services, the Commission noted that broader use of child health measures that are nationally recognized, evidence-based, and standardized could improve the ability to make comparisons across states and payers, and to identify which program characteristics and policies have the greatest impact on quality.[3] The Commission has also focused its attention on high-need populations, recommending in its March 2012 report to Congress that the Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities.

Qualifying Individual Program

The Qualifying Individual (QI) program is one of four Medicare Savings Programs (MSPs) that provide varying levels of assistance with Medicare cost sharing and premiums depending on an individual's income and assets. These are:

- Qualified Medicare beneficiaries (QMBs),
- Specified low-income Medicare beneficiaries (SLMBs),
- Qualifying individuals (QIs), and
- Qualified disabled and working individuals (QDWIs)

See Table 4 for further information on benefits, eligibility, and enrollment for each of the MSPs.

The QI program requires states to pay the Part B premium for Medicare beneficiaries with incomes between 120 and 135 percent FPL (around $13,700 to $15,300 for an individual in 2013), but with 100 percent federal funding. The amount of federal funding available for the program is limited by state-specific allotments that are reauthorized and appropriated by the Congress periodically.

The QI program was most recently extended via the Bipartisan Budget Act of 2013 (H.J. Res. 59) for three months, from December 31, 2013 to March 31, 2014. The legislation allocated $200 million for that time period.

The Commission recognizes the important source of financial protection the MSPs provide for low-income Medicare beneficiaries. In its March 2013 report, the Commission examined Medicaid's role in covering Medicare cost sharing and premiums for low-income Medicare beneficiaries through these programs. In 2011, MSPs provided coverage for Medicare Part A and Part B cost-sharing expenses for 8.3 million persons dually eligible for Medicaid and Medicare, including approximately 500,000 persons enrolled in the QI program who only receive Medicaid coverage of their Part B

premiums and who do not receive full Medicaid benefits, such as benefits for long-term services and supports, in their state (MACPAC 2013).

MACPAC has noted that while QI enrollees, unlike other individuals dually eligible for Medicare and Medicaid, are not full Medicaid enrollees, the program requires administrative coordination between state Medicaid programs and the federal Medicare program. In working to improve efficiency and simplification within Medicaid and across programs, the Commission has identified the Medicare Savings Programs as an area of future work. The Commission plans to assess how Medicare and Medicaid may be better aligned to provide more seamless coverage for these enrollees.

The uncertainty of whether the QI program will be extended has been a source of concern for both states and enrollees alike. An extension would enable many low-income Medicare beneficiaries to continue to receive help paying their Medicare premiums. The Commission will continue to examine these issues and inform the Congress of its work.

Special Needs Plans

Special Needs Plans (SNPs) are Medicare Advantage plans authorized under Title XVIII of the Social Security Act. The Bipartisan Budget Act of 2013 (H.J. Res. 59) extended SNP authority through the end of 2015.

The Commission has been exploring the effectiveness of efforts to improve care coordination for individuals with both Medicare and Medicaid coverage as part of its work on high-cost high-need enrollees. It has examined models of care that provide integrated services to dually-eligible Medicaid and Medicare enrollees including the Program of All-Inclusive Care for the Elderly (PACE) and SNPs. PACE focuses its system of care around individuals age 55 and older with health needs requiring a nursing home level of care. The Commission also has examined systems of care offered

by fully integrated dual-eligible special needs plans (FIDE SNPs), which are dual-eligible special needs plans (D-SNPs) that enter into risk-based contracts with state Medicaid agencies and Medicare to provide certain acute care services, long-term services and supports, and coordination of Medicare and Medicaid services (42 CFR 422.2). Six states (California, Hawaii, Massachusetts, Minnesota, New York, and Wisconsin) have programs that are fully integrated, with the plan at risk for both Medicaid and Medicare services and dually-eligible individuals enrolled in the same managed care plan for both sets of benefits (CMS 2013c). Arizona and Texas require that Medicaid managed care plans offer D-SNP products, but dually-eligible individuals may be enrolled in separate plans for Medicaid and Medicare services (Saucier 2012).

Several states have looked to D-SNPs as a model upon which to build. Many of the requirements for plans participating in the Financial Alignment Initiative being conducted by the CMS, for example, are based on requirements for D-SNP plans. Other states including Arizona and Tennessee propose to align and better integrate services between the two programs by building on existing D-SNPs (AHCCS 2013; TennCare 2012). The Commission continues to monitor and examine the Financial Alignment demonstrations and other state initiatives as they are implemented and plans to provide the Congress with further information on these initiatives as their results become available.

The Commission has not made recommendations specifically regarding the extension of statutory authority for Medicare special needs plans. However, one area we have examined is the development of appropriate risk adjustment methodologies for integrated care models including D-SNPs. Determining payment amounts and the portion of the total plan payment attributable to Medicare versus Medicaid is a key issue in designing integrated care models. The Commission's work highlighted several issues to consider when developing capitation rates for integrated care plans such as D-SNPs, including accounting for voluntary enrollment, the need for better risk

adjustment models and appropriate measures of functional status, and the treatment of supplemental payments (MACPAC 2013). This work is also part of the Commission's broader look at providing services to low-income and special needs populations through managed care.

As the Commission pursues its analytic agenda on payment and access issues related integrated care models specifically and Medicaid managed care more generally, it will keep the Congress informed of its work and recommendations for program improvement.

Conclusion

MACPAC has made specific recommendations to the Congress ending the sunset date for TMA, removing a disincentive for parents to seek employment opportunities without losing Medicaid coverage during the transition and giving states more certainty in program funding. TMA provides continuity of coverage and reduces uninsurance for low-income families on a temporary basis while parents transition to employment or more work hours, a policy the Commission supports funding without a sunset on a permanent basis.

The Commission is actively considering children's coverage in both Medicaid and CHIP. The Commission has highlighted the future of CHIP in the context of new coverage options under the ACA as a priority for 2014 and expects to report to the Congress on these issues in both its March and June 2014 reports. MACPAC will actively review CHIP bonus payments and child health quality measures issues in this context and will keep the Congress informed of our work.

Medicaid's role in providing care for high-cost high-need enrollees, including those dually eligible for Medicare and Medicaid is a MACPAC priority for 2014, building on the Commission's work in this area over the past two years. We will continue to keep the Congress informed of our progress in examining these issues, including the QI program, as analyses are completed.

Thank you, Members of the Subcommittee. I would be happy to answer any questions you may have.

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[1] For example, to continue eligibility for the second six months of TMA, families are required to report on a quarterly basis (in the fourth, seventh and tenth months of their coverage) their gross earnings and child care costs. Five states have used a new state plan option to waive this requirement (MACPAC 2013). However, the number of states implementing this policy under a waiver has not been reported since 2002, when 19 out of 46 reporting states did not require quarterly reporting (Grady 2008).

[2] The other four policies to qualify for CHIPRA bonus payments are 12-month continuous eligibility, presumptive eligibility, Express Lane Eligibility, and premium assistance for employer-sponsored coverage (§2105(a)(4) of the Social Security Act).

[3] http://www.macpac.gov/comment-letters/MACPAC_Comments-HHS_Reports_to_Congress_Dec2010.pdf

TABLE 1. Enrollment and Expenditures (in Millions of Dollars) for Transitional Medical Assistance (TMA), 2011

State	TMA enrollment (43 states reporting)	TMA expenditures (36 states reporting)	Total Medicaid benefit expenditures (36 states reporting)	Percentage of Medicaid benefit spending attributable to TMA (36 states reporting)
Total for states reporting	**3,710,535**	**$4,098.2**	**$301,831**	**1.4%**
Alabama	1,927	$2.3	$4,793	0.0%
Alaska	2,889	-	-	-
Arizona	45,562	-	-	-
Arkansas	3,235	$6.7	$3,952	0.2%
California	336,635	$186.3	$54,065	0.3%
Colorado	64,643	-	-	-
Connecticut	-	-	-	-
Delaware	17,585	-	-	-
District of Columbia	1,332	-	-	-
Florida	424,312	$296.1	$18,128	1.6%
Georgia	111,554	$75.3	$8,065	0.9%
Hawaii	6,271	$11.2	$1,524	0.7%
Idaho	7,089	$15.7	$1,515	1.0%
Illinois	445,481	$563.0	$12,836	4.4%
Indiana	109,114	$91.4	$6,566	1.4%
Iowa	41,180	$45.0	$3,317	1.4%
Kansas	15,632	$21.8	$2,669	0.8%
Kentucky	54,119	$74.4	$5,652	1.3%
Louisiana	24,893	$21.2	$6,298	0.3%
Maine	23,427	$58.2	$2,356	2.5%
Maryland	96,945	$193.2	$7,320	2.6%
Massachusetts	64,886	$100.5	$13,007	0.8%
Michigan	166,496	$313.5	$12,063	2.6%
Minnesota	35,359	$66.8	$8,271	0.8%
Mississippi	37,348	-	-	-
Missouri	109,357	-	-	-
Montana	-	-	-	-
Nebraska	40,903	$50.9	$1,637	3.1%
Nevada	10,297	-	-	-
New Hampshire	-	-	-	-
New Jersey	35,627	$43.9	$10,501	0.4%
New Mexico	50,532	$82.4	$3,318	2.5%
New York	-	-	-	-
North Carolina	-	-	-	-
North Dakota	-	$20.6	$702	2.9%
Ohio	371,193	$525.1	$15,533	3.4%

TABLE 1, Continued

State	TMA enrollment (43 states reporting)	TMA expenditures (36 states reporting)	Total Medicaid benefit expenditures (36 states reporting)	Percentage of Medicaid benefit spending attributable to TMA (36 states reporting)
Oklahoma	86	$0.1	$4,008	0.0%
Oregon	70,197	$103.7	$4,386	2.4%
Pennsylvania	240,330	$319.1	$20,395	1.6%
Rhode Island	8,128	$11.0	$2,099	0.5%
South Carolina	62,190	$117.0	$4,931	2.4%
South Dakota	-	-	-	-
Tennessee	55,669	$139.6	$7,970	1.8%
Texas	135,068	$125.6	$27,847	0.5%
Utah	22,846	$18.4	$1,733	1.1%
Vermont	-	-	-	-
Virginia	20,042	$33.3	$6,894	0.5%
Washington	145,992	$180.4	$7,335	2.5%
West Virginia	3,135	$11.4	$2,740	0.4%
Wisconsin	187,016	$160.7	$6,878	2.3%
Wyoming	4,013	$12.4	$527	2.4%

Notes: The "–" indicates that data were not available from the state. State officials were asked by GAO to provide an unduplicated enrollment number for each year. Alaska and Arizona could not provide unduplicated enrollment data. Officials in 22 states reported enrollment data by state fiscal year, 6 reported by federal fiscal year, 13 reported by calendar year, and 2 reported average monthly enrollments. Expenditures are federal fiscal year.

Sources: For TMA enrollment and expenditures, U.S. Government Accountability Office (GAO), *Medicaid: Additional enrollment and expenditure data for the transitional medical assistance program*, Report no. GAO-13-454R, March 15, 2013, http://www.gao.gov/assets/660/653058.pdf. For total Medicaid benefit spending, MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2012, MACStats Table 6.

TABLE 2. CHIPRA Bonus Payments for Fiscal Year (FY) 2009 to 2013

State	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Alabama	$1,468,033	$5,687,952	$20,356,368	$15,822,112	$11,487,387
Alaska	707,253	4,913,942	5,748,452	4,121,160	2,637,399
Colorado	–	18,203,273	32,906,502	47,490,797	58,489,650
Connecticut	–	–	5,169,927	2,981,808	1,717,085
Georgia	–	–	4,891,788	2,217,833	–
Idaho	–	876,171	458,932	1,446,004	5,402,512
Illinois	9,460,312	15,325,041	15,297,689	13,305,164	6,298,211
Iowa	–	7,702,644	9,955,808	11,448,316	10,615,376
Kansas	1,220,479	5,461,248	5,958,759	12,760,085	10,854,406
Louisiana	1,548,387	3,661,104	1,915,111	–	–
Maryland	–	11,445,344	27,998,890	37,500,197	43,470,168
Michigan	4,721,855	8,436,607	6,893,004	4,377,476	1,602,468
Montana	–	–	5,034,670	7,185,360	7,025,902
New Jersey	3,131,195	8,765,386	17,554,512	24,357,753	22,429,198
New Mexico	5,365,601	8,967,885	5,246,129	2,724,565	1,663,071
North Carolina	–	–	11,567,319	18,594,703	11,589,603
North Dakota	–	–	3,175,469	2,743,944	1,078,574
New York	–	–	–	643,064	13,110,267
Ohio	–	13,127,633	20,819,999	18,966,255	10,829,869
Oklahoma	–	–	481,452	–	–
Oregon	1,602,692	10,567,238	22,323,821	25,923,850	24,393,154
South Carolina	–	–	2,712,649	2,939,771	17,536,595
Utah	–	–	–	9,861,838	5,325,544
Virginia	–	–	24,620,902	19,973,322	18,004,201
Washington	7,861,411	20,649,662	19,014,483	13,763,513	7,844,055
Wisconsin	–	23,432,822	33,261,014	17,128,227	13,917,864
West Virginia	–	–	136,270	–	–
Total payments	**$37,087,218**	**$167,223,952**	**$303,499,919**	**$318,277,117**	**$307,322,559**
Number of states	**10**	**16**	**25**	**24**	**23**

Notes: The "–" indicates that no payments were received by the state in that year. The bonus payments for FY 2013 are considered preliminary and subject to reconciliation after states' Medicaid enrollment numbers are finalized in early 2014.
Source: Centers for Medicare & Medicaid Services (CMS), "CHIPRA Performance Bonuses: A History," December 2013, http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf.